The Interaction between Pharmacotherapy and Psychotherapy in the Treatment of Posttraumatic Stress Disorder

STEVEN M. SOUTHWICK, M.D.*
RACHEL YEHUDA, Ph.D.**

The addition of pharmacotherapy to psychotherapy in the treatment of posttraumatic stress disorder (PTSD) is increasingly common. This paper describes some of the complexities involved in combining these two therapeutic modalities, specifically when pharmacotherapy is added to an ongoing psychotherapeutic treatment of combat-related PTSD.

INTRODUCTION

The addition of a new therapeutic modality to an already ongoing treatment is fraught with complexities. Multiple therapeutic modalities, when used concurrently in the same patient, do not exist in isolation, but rather, interact with one another in important ways. The interaction between pharmacotherapy and individual psychotherapy, for example, has been described in the treatment of a number of psychiatric disorders such as major depressive disorder, borderline personality disorder, and schizophrenia.[1-5] In treating patients with PTSD there appear to be unique considerations reflecting a growing understanding of the biological underpinnings and psychological manifestations of this disorder. This paper will discuss some of the complexities involved in combining pharmacotherapy and psychotherapy in the treatment of patients with chronic, war-related PTSD. We will begin by addressing several issues that commonly arise when psychotherapies are used without accompanying medications. We will next focus on the actual decision to medicate and on a number of factors important for the integration of medication and psychotherapy. Finally, the special setting of the medication clinic and the relationship between medical back-up and primary therapist will be discussed.

*Director, Clinical Neuroscience Division, National Center for Posttraumatic Stress Disorder, Posttraumatic Stress Disorders Program, West Haven, VA Administration, Medical Center; Associate Professor of Psychiatry, Yale University School of Medicine. ***Mailing address:*** Posttraumatic Stress Disorder Program, West Haven, CT, Clinical Neuroscience Division, National Center for Posttraumatic Stress Disorder, West Haven, VAMC 06516.

**Assistant Professor of Psychiatry, Psychiatry Department, Mount Sinai School of Medicine; Director, Posttraumatic Stress Disorders Program, Bronx VAMC.

AMERICAN JOURNAL OF PSYCHOTHERAPY, Vol. 47, No. 3, Summer 1993

PSYCHOTHERAPY WITHOUT MEDICATIONS

An essential component of psychotherapeutic treatment for PTSD involves the remembering and reliving of traumatic experiences with the subsequent psychological detoxification of those memories. One of the greatest risks involved in using psychotherapy without medications is that the veteran may not be able to endure the involuntary symptoms that stem from reliving the traumatic memories in therapy. Often these traumas have been suppressed to such a great extent that once the reliving process is initiated, the memories surface too rapidly, causing an increase in nightmares, recurrent thoughts, and insomnia. Because the traumatic material is so intense, it is not always possible for the therapist to adequately titrate the divulging of painful experiences. As a result, the veteran may feel overwhelmed and become increasingly defensive and avoidant. In some cases, in an attempt to avoid the intensifying symptoms that occur in response to reliving, the patient actually drops out of therapy. The addition of a medication to alleviate some of the intrusive symptoms and to help treat sleep disturbances may allow the patient to continue working through traumatic memories during critical phases of the psychotherapeutic treatment.[6]

In therapeutic settings where medications are not used, some clinicians attempt to provide patients with psychological methods to alleviate intrusive symptoms prior to beginning war-focused therapy. These methods might include anger control, stress management, relaxation techniques, and strategies to improve sleep habits. For some veterans, these techniques can be very helpful. However, for others these techniques do not suppress the involuntary, intrusive symptoms that have been exacerbated by reliving and re-exposure therapies. It now appears that some of these symptoms have an underlying neural component[7,8] that can best be treated by medications. By focusing solely on psychosocial interventions and failing to integrate a biomedical approach, the treater may inadvertently foster a decrease in self-esteem and an intensification of their patients' sense of worthlessness. If patients continue to experience symptoms even while employing the psychosocial techniques they have been taught, feelings of failure and resultant decreases in self-esteem could ensue.

In clinical settings where medications are commonly used in the treatment of war-related PTSD, such as in veteran hospitals, using psychotherapy without medications may result in the therapist being viewed as withholding by the patient. Because other individuals with PTSD will be receiving

medications, the patient may interpret the therapist's decision not to medicate as an indication that the therapist does not believe he/she has a severe illness. While this factor, in and of itself, should not determine a therapists's decision to medicate, the therapist should be aware that this particular issue may affect the psychotherapy. The decision not to medicate should be as clearly thought through as the decision to medicate.

The Decision to Medicate: Countertransference Considerations

Before adding medications to a traumatized patient's existing treatment regimen, therapists should monitor their own countertransference carefully. In a study of psychotherapists' reactions to victims of the Nazi Holocaust, Danielli identified a number of important countertransference themes that frequently arise during therapy with traumatized populations and that undoubtedly impact on the therapists' assessment of medication needs. Within this population, common and intense countertransference themes include the therapists' guilt, rage, shame, grief, inability to contain intense emotions, and need to view the self as liberator-savior.[9] Given the plethora of these potential reactions, it is essential for therapists to understand how their own needs may have entered into the decision to medicate. For example, a therapist may be frustrated with slow progress of the therapy and feel ineffective as a result. The act of prescribing a medication may be the therapists's way of "doing something" constructive in the therapy.

It is also common for therapists to use the prescribing of medications as a way to unwittingly divert attention away from detailed descriptions of aggressive and violent material. Therapists who are uncomfortable with aggression may have difficulty empathically listening to and processing accounts of horrific events. Rather than hearing painful traumatic memories, they may prefer to focus on medication target symptoms like appetite, energy level, and sleep.

Further, therapists may use the prescription of medications as a way to exert their authority. PTSD patients are notorious for challenging all types of authority figures, such as medical personnel. Thus the act of prescribing a medication may allow therapists to gain "control" in the therapeutic relationship. Alternatively, therapists may be primarily concerned with pleasing their patients who request or at times demand medications. A number of these issues have been addressed by Goldhammer in the treatment of patients with borderline personality disorder.[10]

The Integration of Medications and Psychotherapy

Once contraindications, target symptoms, and potential countertransference issues have been assessed and dealt with, the therapist may rationally

decide whether or not to medicate the patient. There are several strategies that can be used to integrate the two treatments in order to achieve maximal therapeutic benefit.

First, it is important to maintain a psychotherapeutic focus. Both the therapist and the patient should resist the temptation to address medication target symptoms and side effects to the exclusion of ongoing psychotherapeutic themes. The focus on medications may serve as a defense (for both patients and therapist) against dealing with difficult psychotherapeutic issues. Some patients will respond to the addition of a medication by beginning to view their disorder as strictly a "biochemical imbalance" that no longer requires psychotherapy and for which they are not responsible. Such a response should be treated like any other defense, that is, analyzed.

A second consideration in the addition of a medication to psychotherapy is the symbolic meaning of the medication to the patient. If the patient has never taken medications before for this illness, he/she may have unreasonable hopes for a magical cure to be delivered by an omnipotent parent-like figure. Additionally, the patient may view the medication as a gift from the physician, and as such may perpetuate the patient's wish to be ministered to and to be dependent. Furthermore, for many traumatized patients medications can be invested with the special qualities of the prescriber. They can, in essence become transitional-like objects. When this is the case, the meaning invested by patients becomes an important therapeutic issue particularly with respect to efficacy, self-destruction, and compliance. It is alternatively possible that patients may see the medications as a form of rejection with the message that the treater does not wish to talk with them, but instead wishes to dismiss them: the proverbial "Take two aspirin and call me in the morning." Furthermore, patients may interpret the prescription of medications as a message that they are indeed sick and incapable of controlling their own behavior. Like any other act, the prescribing of medications has meaning to the patient and should be understood in the context of the therapist-patient relationship.

Medications are most helpful to patients when they are fully integrated into therapy rather than being viewed as separate foreign objects. For example, antidepressants can dampen down involuntary re-experiencing symptoms such as flashbacks and nightmares, particularly, when used in conjunction with insight-oriented therapy. By modifying involuntary re-experiencing symptoms that follow intense and painful memories in psychotherapy, antidepressants allow patients to more freely experience, work through, and master the trauma. An analogous example of integrating therapies comes from the panic-agoraphobia literature where antidepres-

sants are often successfully used to treat involuntary panic attacks but have relatively little effect on agoraphobia symptoms. Symptoms of agoraphobia, however, may respond to behavioral interventions such as systematic desensitization or flooding. The combination of antidepressants and behavioral treatment may be necessary to treat the full range of panic and agoraphobia symptoms.

Staging is also important when attempting to integrate treatment modalities. For example, with panic and agoraphobia if behavioral therapy is initiated before the control of panic symptoms, panic attacks will not yet be blocked and re-exposure may simply cause more attacks. Similarly, some patients with PTSD may experience a pronounced increase in intrusive nightmares and flashbacks if probing insight-oriented therapy or behavioral flooding is begun prior to pharmacologic treatment. Furthermore, pharmacologic interventions may be useful during some phases of treatment but not during others. For example, antidepressants may be most useful during reliving phases of treatment but no longer necessary when treatment is focused on rehabilitation and reintegration with civilian life.

The Special Setting of the Medication Clinic

In many mental health facilities the psychiatrist serves as a medical back-up for nonphysician mental health personnel, such a clinical psychologists or social workers. There are numerous challenges associated with medication clinics for both non-M.D. and M.D. treaters. The psychotherapist, in conjunction with the physician back-up, must understand and be prepared to deal with complications that could impact on psychotherapy.

Medication clinics tend to be impersonal and may cause patients to feel dehumanized. This is particularly problematic for ex-combat soldiers who are already sensitized, having been repeatedly treated in a depersonalized manner while in the military. When these patients once again feel dehumanized they tend to act out their feelings either in the medication clinic or in the primary therapeutic setting, leaving the individual therapist puzzled and frustrated.

It is possible, for example, that the prescribing physician becomes inappropriately viewed as the "good healer," that is, the one who gives the patient "tangible help."Alternatively, however, the physician may become the target for intolerable negative transference themes that have been redirected or displaced from the primary therapeutic setting, making it more difficult for the primary therapist to address and work thorough these important negative themes. That is, assigning medication prescription to a separate clinic tends to promote a variety of defense mechanisms, most

commonly, splitting. If the prescribing physician is not prepared for the positive and negative transference distortions, he or she may react in accordance with these distortions. When a patient proclaims to the physician in a medication clinic: "Oh, finally I have gotten some help," it is important that the physician not join in the split by subtly agreeing with the patient, even though it may by gratifying to hear such praise. Conversely, when the patient accosts the physician with negative statements and attitudes, the physician should not immediately reject the patient but rather attempt to recognize the potential source of these at times displaced distortions. Frequent and open communication between primary therapist and medical back-up can often attenuate these problems.

SUMMARY

For patients with PTSD, the effective initiation of additional therapeutic modalities to ongoing individual psychotherapy is challenging. When pharmacologic agents are added, the therapist must carefully consider and monitor the impact of medications on PTSD core symptoms and on adjunctive symptoms such as depression. Further considerations include issues of countertransference, the possible symbolic meaning of medications for both the patient and the therapist, and the appropriate staging of medications. When nonphysician treaters work together with a medical back-up, both parties should frequently communicate with one another in order to avoid unnecessary treatment distortions and disruptions.

Acknowledgment: We respectfully acknowledge Dr. Earl L. Giller, Jr. for his valuable mentorship, advice, and thoughtful suggestions.

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Psychotherapy vs. Pharmacotherapy: Are Psychiatrists Polarized?—A Survey of Academic and Clinical Faculty

MARK SULLIVAN, M.D., Ph.D.*
JOHAN VERHULST, M.D.**
JOAN RUSSO, Ph.D.***
PETER ROY-BYRNE, M.D.****

The degree to which community clinical psychiatric practice is polarized between psychological and biological treatments is not known. We surveyed academic and clinical psychiatric faculty to determine treatment practices and rationales in three cases with both Axis I and Axis II diagnoses. In each case, greater than 95% would utilize psychotherapy and 75% would consider its omission inappropriate. Medication use varied significantly from case to case.

INTRODUCTION

There are signs of increasing polarization in psychiatry: societies, journals, and meetings are devoted to exclusively psychological or biological conceptualizations of mental illness. The recent debate concerning the *Osheroff vs. Chestnut Lodge* case[1,2] documented in the *American Journal of Psychiatry* further demonstrates the potential for fragmentation of psychiatry into opposing treatment philosophies. Eisenberg[3] warned that psychiatric theory is in danger of breaking apart into a "mindless" (e.g., purely biological) and a "brainless" (e.g., purely psychological) branch.[3] It is not clear whether the clinical practice of community psychiatrists is polarized.

Contemporary psychiatry confronts the challenge of determining the optimal way to balance psychotherapy and pharmacotherapy. Psychiatric practitioners confront daily the problem of finding the proper integration of psychotherapy and pharmacotherapy in the care of patients. However, due

*Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Washington. ***Mailing address:*** Department of Psychiatry and Behavioral Sciences, RP-10, University of Washington, Seattle, WA 98195.
**Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington.
***Research Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of Washington.
****Professor, Department of Psychiatry and Behavioral Sciences, University of Washington.

AMERICAN JOURNAL OF PSYCHOTHERAPY, Vol. 47, No. 3, Summer 1993